Assurant Learning & Performance Solutions

Resource Guide

Behavioral Health and Trauma Informed Care

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Wisconsin Dells, WI

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Behavioral Health Regulations by Phase

Assurant Learning & Performance Solutions

F-Tag	Title	Phase 1	Phase 2	Phase 3	SQC
644	Coordination of PASARR & Assessments				
645	PASARR Screening for MD and ID				
699	Trauma Informed Care				
740	Behavioral Health Services				
741	Sufficient/ Competent Staff - Behavior Health Needs				
742	Treatment/ Service for Mental/ Psychosocial Concerns				
743	No Pattern of Behavioral Difficulties Unless Unavoidable				
744	Treatment/ Service for Dementia				
745	Provision of Medically Related Social Services				
838	Facility Assessment				
943	Abuse, Neglect, & Exploitation Training				
949	Behavioral Health Training				

Tag can be cited at an SQC level

Implementation Date

Gaps in training and facility assessment implementation may create noncompliance in other areas.

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Resource Guide

General Resources

Resource	Notes	Link
CMS Nursing Home Webpage	Houses updates to all CMS documents related to Long-Term Care, including FAQs, Critical Element Pathways and a revision log that shows when specific documents are updated.	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
QSO-19-09-ALL	Revisions to Appendix Q and Guidance on Immediate Jeopardy. Includes updated guidance on psychosocial harm.	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf
State Operations Manual (SOM)	Revised 11/22/17	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf
CMS Surveyor Training	This site includes numerous trainings developed for and used by surveyors across all provider types. Follow the path below to access the trainings: ➢ I am a provider ➢ Course Catalog ➢ Use the search or “filter by” features to locate courses.	https://surveyortraining.cms.hhs.gov/index.aspx
CMS Psychosocial Severity Guide	Tool used by surveyors to determine scope and severity for psychosocial concerns.	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156SOMA.pdf

Training Resources

Resource	Notes	Link
Mental Health First Aid	8 hour face-to-face Behavioral Health Training listed in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence Based Programs and Practices. ***Contact:*** Deborah Ward Deborah.Ward@Assurantlps.com 443-857-8181	http://www.assurantlps.com/services
Resilience for All Ages	Trauma Informed Toolkit and Training created by LeadingAge Maryland and HFAM ***Contact:*** Jill Schumann jschumann@leadingagemaryland.org 410-274-2893	https://www.leadingagemaryland.org/page/RFA

Behavioral Health and Substance Use Disorder Resources

Resource	Notes	Link
National Center for PTSD	Homepage for VA resources on PTSD and other behavioral health topics	https://www.ptsd.va.gov/index.asp
Opioid Use in the Older Adult Population	Overview of opioid use for older adults. Published 2017	https://www.samhsa.gov/capt/sites/default/files/resources/resources-opiod-use-older-adult-pop.pdf
Linking Older Adults with Medication, Alcohol, and Mental Health Resources Toolkit	helps service providers for the aging learn more about mental illness and substance use disorders in older adults, including focus on alcohol and medication use. It provides tools such as a program coordinator's guide, suggested curricula, and handouts.	https://store.samhsa.gov/product/Linking-Older-Adults-With-Medication-Alcohol-and-Mental-Health-Resources/sma03-3824
A Day in the life of Older Adults: Substance Use Facts	Data on use and treatment	https://www.samhsa.gov/data/sites/default/files/report_2792/ShortReport-2792.html
PTSD Awareness in Health Care Settings	15 min. video on PTSD awareness within healthcare settings	https://www.ptsd.va.gov/appvid/video/pro_videos.asp

Trauma Informed Care Resources

Resource	Notes	Link
Ground Rules for Working with Trauma Survivors	The Mighty is a digital health community created to empower and connect people facing health challenges and disabilities.	https://themighty.com/2018/01/ground-rules-for-working-with-trauma-survivors/
Adverse Childhood Experiences (ACES)	Overview of ACES risk factors, research and tools	https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
Understanding the Impact of Trauma	Behavioral Health Provider Focused	https://www.ncbi.nlm.nih.gov/books/NBK207191/
Life Events Checklist (LEC-5)	Screening Tool	https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp
Primary Care PTSD Screen for DSM-5	Screening Tool	https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
Provider Self Care Toolkit	This toolkit is for providers who work with those exposed to traumatic events, to help reduce the effects of job-related stress, burnout, and secondary traumatic stress.	https://www.ptsd.va.gov/professional/treat/care/toolkits/provider/
Provider education: Secondary Traumatic Stress and Burnout	1-hour course that reviews the research on burnout and secondary traumatic stress (STS). Users can assess their own levels of burnout and STS before learning about a variety of coping strategies for offsetting the effects of each.	https://www.ptsd.va.gov/professional/continuing_ed/provider_burnout_strategies.asp

Terms & Definitions

Term	F-Tag	Definition
Intellectual Disability (ID)	644, 645	is defined in 42 CFR 483.102(b)(3), as follows: An individual is considered to have intellectual disability (ID) if he or she has— A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual's Disability Manual on Classification in Intellectual Disability (1983); or A related condition as defined by §435.1010 of this chapter.

Mental Disorder (MD)	644, 645	For purposes of this section, the term "mental disorder" is the **equivalent of "mental illness"** used in the definition of serious mental illness in 42 CFR 483.102(b)(1), which states: An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness: 1. Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987. This mental disorder is— A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section. 2. Level of impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis: a. Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation; b. Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and c. Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

Term	F-Tag	Definition
		3. Recent treatment. The treatment history indicates that the individual has experienced at least one of the following: A. Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or B. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.
Persons with Related Conditions	644, 645	is defined in 42 CFR 435.1010 as follows: Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: a) It is attributable to— 1) Cerebral palsy or epilepsy; or 2) Any other condition, other than a mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. b) It is manifested before the person reaches age 22. c) It is likely to continue indefinitely. d) It results in substantial functional limitations in three or more of the following areas of major life activity: 1) Self-care. 2) Understanding and use of language. 3) Learning. 4) Mobility. 5) Self-direction. *6)* Capacity for independent living.

Term	F-Tag	Definition
Preadmission Screening and Resident Review (PASARR)"	644, 645	is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. Regulations governing PASARR are found at 42 CFR §§483.100-483.138.
Specialized Services for MD or ID	644, 645	means the services specified by the State that exceed the services ordinarily provided by the nursing facility (NF) under its per diem rate. These services must be provided or arranged by the state and could include hiring additional staff or contractors such as qualified mental health/intellectual disability professionals. When specialized services are combined with services provided by the nursing facility, the result is a continuous and aggressive implementation of an individualized plan of care for individuals with MD or ID. The resident's Level II PASARR identifies the specialized services required by the resident.
Rehabilitative services for MD or ID	645	refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff that come into contact with any resident who has as mental disorder or who has intellectual disability. These services are necessary regardless of whether or not they are specified in the PASARR Level II documents and whether or not the resident requires additional services to be provided or arranged for by the State.
Highest practicable physical, mental, and psychosocial well-being	740, 744	is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual
Mental disorder	740, 741	is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013.).

Term	F-Tag	Definition
Substance use disorder	740	is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems or disability (Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA) definition found at http://www.samhsa.gov/disorders/substance-use).
Non-pharmacological intervention	741	refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.
Mental and psychosocial adjustment difficulty	742	refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms. (Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.).
Dementia	744	is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptomology and rates of progression. (Adapted from: "About Dementia." Alzheimer's Foundation of America. 30 Nov 2016. Accessed at: https://www.alzfdn.org/AboutDementia/definition.html)
Medically-related social services	745	means services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health.
Staff	943	includes for the purposes of the training guidance, all facility staff, (direct and indirect care and auxiliary functions) contractors, and volunteers.
Competency	838	A measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully.

Investigative Protocols

Investigative protocols are found in the state operations manual (SOM) in association with the F-Tags. They provide direction to the surveyor on how to investigate potential noncompliance.

F-741 Sufficient/ Competent Staff-Behav Health Needs

Use the Activities Critical Element pathway and the guidance above to investigate concerns related to activities which are based on the resident's comprehensive assessment and care plan, and meet the resident's interests and preferences, and support his or her physical, mental, and psychosocial well-being.
While there may be situations where a pharmacological intervention is indicated first, these situations do not negate the obligation of the facility to also develop and implement appropriate non- pharmacological interventions.

Note: This guidance is not intended to exclude the use of pharmacological interventions when they are clinically necessary and appropriate. Please see the Pharmacy Services section under §483.45(d) (F757), Unnecessary Drugs and §483.45(e) (F758), Psychotropic Drugs for additional guidance.

Determination of Sufficient Staffing
One factor used to determine sufficiency of staff (including both quantity and competency of staff) is the facility's ability to provide needed care for residents as determined by resident assessments and individual care plans. A staffing deficiency must be supported by examples of care deficits caused by insufficient quantity or competency of staff. The surveyor's investigation will include whether inadequate quantity or competency of staff prevented residents from reaching the highest practicable level of well-being.

A deficiency of insufficient staffing is determined through observations, interviews, and/or record reviews. Information gathered through these sources will help the surveyor in determining non-compliance. Concerns such as expressions or indications of distress by residents or family members, residents living with mental, psychosocial, and/or substance use disorders who lack care plan interventions to address their individual needs, lack of resident engagement, and the incidence of elopement and resident altercations, can also offer insight into the sufficiency and competency of staff and the adequacy of training provided to them to care for residents with behavioral health needs.

Determination of Staff Competencies
As required under §483.70(e) (F838), the facility's assessment must include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. The facility must have a process for evaluating these competencies.

If sufficient and/or competent staffing concerns are present during the surveyor's investigation or while completing the Sufficient and Competent Staffing Facility Task refer to the Behavioral and Emotional Status (CMS-20067) Critical Element Pathway.

F-742 (SQC) Treatment/Svc for Mental/Psychosocial Concerns

Objectives
The objectives of this protocol are to determine, based on the comprehensive assessment of a resident, that the facility ensured that the resident who displays or is diagnosed with a mental or psychosocial

adjustment difficulty, or who has a history of trauma and/or PTSD receives the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning.

Procedures

In order to guide observations, briefly review the comprehensive assessment and interdisciplinary care plan.

Observations

Observe for manifestations related to mental and psychosocial adjustment difficulties, a history of trauma and/or PTSD which may, over a period of time, include:

- Impaired verbal communication without physiological cause;
- Social isolation and withdrawal inconsistent with the resident's usual demeanor;
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Deviation from past spiritual beliefs or rituals (alterations in one's belief system);
- Inability to control behavior, anger, and the potential for physical harm to oneself or others; and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

NOTE: Observe staff interactions with the resident in formal and informal situations and determine whether or not they implement interventions in accordance with the care plan.

Interviews

Resident/Resident Representative

Interview the resident, resident's family, or representative(s), to the degree possible, to determine:

- Awareness of the current condition(s) or history of the condition(s) or diagnosis/diagnoses;
- Participation in the development of a person-centered care plan;
- Whether or not resident choices and preferences are considered; and
- Validity of observations and data collection.

Staff Interviews

Interview IDT member(s) as necessary to determine:

- Whether or not care provided is consistent with the care plan; and
- That staff are knowledgeable about how to support the resident when they are expressing or indicating feelings of distress;

Additionally, speaking to staff on various shifts can help to determine:

- Staff knowledge of facility-specific guidelines and protocols related to the treatment of mental disorders and psychosocial adjustment difficulties, history of trauma, and PTSD;
- Whether certified nurse aides (CNA) know how, what, when, and to whom to report changes in condition;
- How facility staff monitor care plan implementation, and changes in condition; and
- How changes in both the care plan and the resident's condition are communicated to the staff.

Record Review

- Identify if the resident triggers Care Area Assessments (CAA) for activities, mood state, psychosocial well-being, and psychotropic drug use.
- ○ Consider whether the CAA process was used to assess the causal factors for decline, potential for decline, or lack of improvement.
- Review the resident's care plan for interventions to address the assessed problem.
- How are mental and psychosocial adjustment difficulties, a history of trauma, and/or PTSD addressed in the care plan?

  - Does it describe the expressions or indications of distress that the resident has experienced because of the assessed problem?
  - Does it describe the programs and activities that have been implemented to assist the resident in reaching and maintaining the highest level of mental and psychosocial functioning?
  - Is the care plan written in measurable language that allows assessment of its effectiveness?
- Are the data to be collected to evaluate the effectiveness of the care plan identified?
- Are the data collection done according to the care plan?
- Is there an assessment of the resident's usual and customary routines and preferences?
- o Are accommodations made by the facility to support the resident by incorporating these routines and preferences in the care plan?
- Does record review indicate that the care and services outlined in the care plan are effective in decreasing the resident's expressions or indications of distress?
- If the data collected indicate that expressions or indications of distress are unchanged in frequency or severity over two or more assessment periods, is the plan reassessed and intervention approaches revised to support the resident in attaining the highest practicable mental and psychosocial well-being?

NOTE: Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty may include, *but are not limited to:*

- Metabolic or endocrine disorders (e.g., Cushing's disease, diabetes/hypoglycemia, hypothyroidism);
- Central nervous system disorders (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease);
- Miscellaneous conditions (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure, hypotension, dehydration, circadian rhythm disruption);
- Over-medication for treatment of other conditions; and
- Use of restraints.

F-743 (SQC) No Pattern of Behavioral Difficulties Unless Unavoidable

Objectives

The objective of this protocol is to determine whether or not the facility meets the regulatory requirements for a resident who has displayed a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive expressions or indications of distress.

Procedures

Briefly review the comprehensive assessment and interdisciplinary care plan to guide observations.

Observations

Observe residents who appear to be isolated, withdrawn, angry, or have other expressions or indications of mental or psychosocial difficulties, a history of trauma and/or PTSD. Additionally, observations may include, but are not limited to:

- Staff and resident interactions;
- Demonstration of the staff's understanding, responsiveness, and proactive care for residents' needs; and
- Implementation of care plan interventions by staff.

Interviews

Resident/Resident Representative

Interview the resident, resident's family, or representative(s), to the degree possible, to determine:

- The level of social interaction and distress that was present upon admission;
- Whether social interaction has diminished or increased since admission;
- If withdrawal, anger, and depressive expressions or indications of distress have increased without a change in the resident's clinical condition;
- Participation in the development of a person-centered care plan; and
- Whether or not resident choices and preferences are considered.

Staff Interviews

In the case where staff members have noted changes in a resident's social interactions and behaviors after admission to the facility, and the care plan does not reflect these changes, the surveyor must: Interview IDT member(s) as necessary to determine:

- Whether or not facility staff are aware of changes in the resident's social interactions and/or behavior;
- That staff are knowledgeable about how to support the resident when they are expressing or indicating feelings of distress;
- Whether or not facility staff, including the resident, their family, and/or resident representative have reviewed the resident's care plan and revised it as necessary, to reflect the resident's current needs and goals.
- Additionally, speaking to staff on various shifts can help to determine:
    - Their knowledge of facility-specific guidelines and protocols related to the treatment of mental disorders and psychosocial adjustment difficulties, history of trauma, and PTSD;
    - Whether certified nurse aides know how, what, when, and to whom to report changes in condition, including changes in a resident's social interactions and behaviors (e.g., residents who have begun to withdraw, express anger, and/or depression);
    - How facility staff monitor the implementation of the care plan, and respond to changes in the resident's social interactions and behaviors; and
    - How changes in both the care plan and the resident's condition are communicated to the staff.

Record Review

- Determine whether or not upon admission, the resident had a diagnosis of or displayed a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD.
- Review the resident's medical record for documentation related to a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive expressions or indications of distress. Review nursing, social service, mental health notes, or other discipline notes for description of the distress.
- Review the Resident Assessment Instrument (RAI) and identify if the Minimum Data Set (MDS) captures and was used to assess the resident's conditions. Look to see that the resident Care Area Assessments (CAA) for activities, mood state, psychosocial well- being, and psychotropic drug use trigger for any reason in the absence of related diagnoses or difficulties, or history of trauma and/or PTSD.
- Consider whether the CAA process was used to identify and assess the reason and causal factors for decline, potential for decline, or lack of improvement.
- Is there an assessment of the resident's usual and customary routines and preferences?
- o Are accommodations made by the facility to support the resident by incorporating these routines and preferences in the care plan?
- Review the resident's care plan to determine if interventions are in place to alleviate the assessed distress.
    - Does it thoroughly describe the distress from a person-centered perspective?
    - Does it describe the programs and activities that have been implemented to assist the resident in reaching and maintaining the highest level of mental and psychosocial functioning?
    - Is the care plan written in measurable language that allows assessment of its effectiveness?
    - Does the record review indicate that the care and services outlined in the care plan are effective?

Critical Element Pathways

PASRR Form CMS 20090

Behavioral and Emotional Status Critical Element Pathway Form CMS-20067

Dementia Care CMS Form 20133

Preadmission Screening and Resident Review Critical Element Pathway

Use this pathway for a resident who has or may have a serious Mental Disorder (MD), Intellectual Disability (ID) or a Related Condition to determine if facility practices are in place to identify residents with one of these conditions and to determine if Level I PASARR screening has been conducted and referrals have been made to the appropriate state-designated authority for Level II PASARR evaluation and determination.

Review the following to Guide Observations and Interviews:

- ☐ Review the most current comprehensive MDS and CAAs for Sections A – PASARR and conditions (A1500-A1580), I – Active Diagnoses - psychiatric/mood disorders (I5700-I6100), N – Medications (N0410), and O – Special Treatment/Proc/Prog – psychological therapy (O0400).
- ☐ Physician's orders (e.g., psychoactive medications).
- ☐ Pertinent diagnoses/conditions.
- ☐ Level I PASARR screening results and Level II PASARR evaluation and determination, if appropriate.

Resident, Representative, or Family Interview:

- ☐ Can you tell me about your current diagnosis/condition (e.g., MD, ID, or mood concerns)?
- ☐ Did you have this diagnosis/condition prior to your admission to this facility?
- ☐ Do you receive any specialized services to help with your mental health or disability concerns? If not, why not? If so, describe.
- ☐ What are they doing to address your mental health or disability concerns (e.g., behavior management plan, ID interventions, meds, level II recommended interventions)?

Staff Interviews (Nurses, DON, Social Worker):

- ☐ What is the facility's process for identifying residents with a possible MD, ID or a related condition prior to admission to the facility?
- ☐ How does the facility identify residents with newly evident or possible serious MD, ID or a related condition after admission to the facility?
- ☐ Who is responsible for making the referral to the appropriate state-designated authority when a resident is identified as having an evident or possible MD, ID or related condition?
- ☐ If a resident is identified as having newly-evident or possible MD, ID or a related condition after admission, what is the facility's process for referring the resident to the appropriate state-designated authority?
- ☐ If the resident was identified as having evident or possible MD, ID or a related condition, and a referral to the appropriate state-authority was not made, ask why.

Preadmission Screening and Resident Review Critical Element Pathway

Record Review:

- ☐ Did the resident have an MD, ID or related condition at the time of admission or was the condition identified after admission?
- ☐ Was a Level I screen for possible MD, ID or a related condition completed prior to admission OR if the resident was expected to be in the facility less than 30 days and remained in the facility more than 30 days (as allowed by the State) was a Level 1 screen performed?
- ☐ If the Level I screening process identified evident or possible MD, ID or a related condition, was a referral made to appropriate state-designated authority for Level II PASARR evaluation and determination?
- ☐ Review facility policies and procedures regarding Level I screening (e.g., the criteria that would require a Level II evaluation) and referral for Level II PASARR evaluation and determination.
- ☐ If a Level II evaluation should have been done but wasn't, what mental health or disability services are being provided (e.g., social service interactions or counseling)? [If concerns are identified, initiate the Behavior pathway.]
- ☐ Was there a "significant change" in the resident's condition (i.e., a decline in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting, and impacts more than one area of health and requires IDT review, and/or revision of the care plan)?
- ☐ If yes, was a significant change in status assessment conducted within 14 days of determining the change was significant?
- ☐ If the significant change in status was related to a new or possible MD, ID or related condition, did the facility notify the state-designated mental health or ID authority timely?
- ☐ Did the facility incorporate the recommendations from the PASARR Level II determination and evaluation report into the resident's assessment and care plan?

Critical Elements Decisions:

1) Is there evidence of Level I pre-screening of the resident to determine if the newly admitted resident had or may have had a MD, ID or a related condition prior to admission to the facility?
   If No, cite F645
   NA, the resident entered the facility as an exception (an exempted hospital discharge), in accordance with the State PASARR process, and has been in the facility less than 30 days.

2) If pre-admission screening of residents expected to be in the facility 30 days or less is not performed, in accordance with the State PASARR process, and the presumed short-stay resident was not screened prior to admission to the facility and remained in the facility longer than 30 days, did the facility screen the resident to determine if the resident had or may have had an MD, ID or a related condition?
   If No, cite F645
   NA, Level I pre-screening of the resident was performed prior to admission to the facility or the resident was in the facility less than 30 days.

Preadmission Screening and Resident Review Critical Element Pathway

3) If the Level I pre-screening of the resident, either prior to admission or within 30 days, in accordance with the state PASARR process, identified that the resident had or may have had an MD, ID or related condition, did the facility refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination?
   If No, cite F645

4) For a resident who had a negative Level I pre-screen, who was later identified with newly evident or possible serious MD, ID or a related condition, did the facility refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination?
   If No, cite F644
   NA, the resident was not later identified with newly evident or possible serious MD, ID or a related condition.

5) For a resident with a Level II, did the facility coordinate assessments with the PASARR program by incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's assessment, care planning, and transitions of care?
   If No, cite F644
   NA, the resident did not have a Level II.

6) If the resident's significant change in status was related to newly evident or possible MD, ID or related condition, did the facility notify the appropriate state-designated mental health or ID authority for a Level II evaluation as soon as the criteria indicative of a significant change in status was evident?
   If No, cite F644
   NA, the resident did not have a signicant change in status related to newly evident or possible MD, ID or related condition.

7) Did the facility notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for a review?
   If No, cite F646
   NA, the resident did not have a signicant change in mental or physical condition.

8) For the newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

9) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

10) If there was a significant change in the resident's status, did the facility complete a significant change in status assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

11) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

12) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

13) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary, to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: QOL F675, Behavior and Emotional (CA), Social Services F745, Rehab and Restorative (CA), Rehab Services Qualified Staff F826, Qualification of Social Worker F850, Facility Assessment F838, Resident Record F842, QAA/QAPI (Task).

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ☐ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How does staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Behavioral and Emotional Status Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ☐ Awareness of current conditions or history of conditions or diagnoses.
- ☐ How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?
- ☐ How does the facility ensure approaches to care reflect your/the resident's choices and preferences?
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- ☐ How are the resident's individual needs being met through person-centered approaches to care?
- ☐ What are your or the resident's concerns, if any, regarding the resident's mood?
- ☐ Have you or the resident had a change in mood? If so, please describe.
- ☐ What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- ☐ What other non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- ☐ What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rational for each intervention?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is provided that is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ What types of behavioral health training have you completed?
- ☐ Ask about any other related concerns the surveyor has identified.
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

Behavioral and Emotional Status Critical Element Pathway

Record Review:

- ☐ Review therapy notes and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident.
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress, such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ What PASARR Level II services or psychosocial services are provided, as applicable?
- ☐ Does the facility ensure residents with substance use disorders have access to counseling programs (e.g., 12 step groups)?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Was behavioral health training provided to staff?

Critical Element Decisions:

1) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
   If No, cite F740

2) Does the facility have sufficient and competent direct care staff to provide nursing and related services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?
   If No, cite F741

Behavioral and Emotional Status Critical Element Pathway

3) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD)?

   If No, cite F742
   NA, the resident does not display or is not diagnosed with a mental or psychosocial adjustment difficulty, or does not have a history of trauma and/or PTSD.

4) Did the facility ensure that the resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable?

   If No, cite F743
   NA, the resident's assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

5) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?

   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

6) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?

   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

7) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?

   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.

Behavioral and Emotional Status Critical Element Pathway

8) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths, and areas of decline accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

9) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

10) Did the facility reassess the effectiveness of the interventions and, review and revise the resident's care plan (with input from the resident, or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Social Services F745, Unnecessary/Psychotropic Medications (CA), Resident Records F842.

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Most current comprehensive and most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, E – Behavior and N – Medications.
- ☐ Physician orders.
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided? If so, what evidence was observed?
- ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice?
- ☐ Are staff using non-pharmacological interventions to attain or maintain the resident's well-being?
- ☐ How does the facility modify the environment to accommodate the resident's care needs?
- ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
- ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741.

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
- ☐ How did the facility involve you/the resident in the care plan and goal development process?
- ☐ How did the facility consider your/the resident's choices and preferences?

Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to determine what type of social services or referrals have been implemented.

Dementia Care Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) Across Various Shifts:

- ☐ How do you ensure care is provided that is consistent with the care plan?
- ☐ Can you tell me about the resident's care plan and his/her condition (including underlying causes)?
- ☐ What are the facility's dementia care guidelines and protocols?
- ☐ What types of dementia management training have you completed?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
- ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and include measurable objectives and timetables? Has the care plan been revised to reflect any changes?
- ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ Was dementia management training provided to staff?

Dementia Care Critical Element Pathway

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measureable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a Significant Change in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant changed in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, QOL F550 or F675, QOC F684, Physician Services F710, Social Services F745, Unnecessary/Psychotropic Medications (CA), Sufficient and Competent Staffing (Task).

Make a Note for Follow-up

Instructions: During today's session we talked about competencies and regulatory requirements. What do you want to follow-up on after you return to work?

1. Briefly rate your perceptions of your organizations strengths and weaknesses on high level competencies associated with behavioral health care.

Strength/ Weakness	Competency
	Promotes psychosocial and emotional well-being
	Identifies signs and symptoms of **trauma**
	Identifies signs and symptoms of **mental disorders**
	Identifies signs and symptoms of **suicide** and/or **self-harm** ideation and behaviors.
	Identifies signs and symptoms of **non-mental disease/ disorder states** (where the symptoms mimic a mental disorder)
	Connects residents to appropriate mental health services, including substance use disorder services
	Connects residents to self-help and other (non-professional) support strategies
	Identifies and implements behavioral health elements of the care plan
	Measures and responds to outcomes associated with non-pharmacological interventions for each resident
	Listens non-judgmentally to concerns and expressions of distress from residents and colleagues.
	Communicates kindly/ respectfully using a clear and direct manner
	Offers support and reassurance to residents (and others) who are experiencing distress

2. Regulatory Prep – Which of the regulations listed below are you implementing/ ready to implement?

F-tag	Description	Readiness Scale						
F644	Coordination of PASARR and Assessments	Less	1	2	3	4	5	More
F645	PASARR Screening for MD and ID	Less	1	2	3	4	5	More
F699	Trauma Informed Care	Less	1	2	3	4	5	More
F740	Behavioral Health Services	Less	1	2	3	4	5	More
F741	Sufficient/Competent Staff - Behavior Health Needs	Less	1	2	3	4	5	More
F742	Treatment/Service for Mental/Psychosocial Concerns	Less	1	2	3	4	5	More
F743	No Pattern of Behavioral Difficulties Unless Unavoidable	Less	1	2	3	4	5	More
F744	Treatment/Service for Dementia	Less	1	2	3	4	5	More
F745	Provision of Medically Related Social Services	Less	1	2	3	4	5	More
F838	Facility Assessment	Less	1	2	3	4	5	More

3. Disease and non-disease states – Are there any your staff need more training on?